

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

63-034029

DO NOT WRITE
ON THIS STUB

AMENDED

Registration District No.

318

Primary Registration District No.

1003

Registrar's No.

8740

STATE FILE NUMBER

FILED SEP 6 1963

1. PLACE OF DEATH

a. COUNTY

b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN St. Louis

Length of stay in 1b
17 da.

2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Mo b. COUNTY

c. CITY
OR
TOWN St. Louis

Inside Limits
Yes ☒ No ☐

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION St. L. Chronic Hosp.

Inside Limits
Yes ☒ No ☐

d. STREET ADDRESS (If outside, give location)
508 Chestnut

Reside on Farm
Yes ☐ No ☒

3. NAME OF DECEASED

(Type or print)

First
Pearl

Middle

Last
Reed

4. DATE
OF
DEATH

Month
8

Day
24

Year
63

5. SEX
F

6. COLOR OR RACE
W

7. Married ☐ Never Married ☐
Widowed ☒ Divorced ☐

8. DATE OF BIRTH
11-6-02

9. AGE (last birthday)
60

IF UNDER 1 YEAR
Months Days

IF UNDER 24 HR
Hours Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

none

10b. KIND OF BUSINESS OR INDUSTRY

none

11. BIRTHPLACE (City and state or country)
Mo.

12. CITIZEN OF WHAT COUNTRY
USA

13a. FATHER'S NAME

unknown

13b. MOTHER'S MAIDEN NAME

unknown

14. NAME OF HUSBAND OR WIFE

John

15. WAS DECEASED EVER IN U.S. ARMED FORCES (Yes, no, or unknown) (If yes, give war or dates)

unknown

17. INFORMANT

Address

St. Vincent dePaul 4140 Lindell.

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Pulmonary embolus

INTERVAL BETWEEN ONSET AND DEATH

5 hours

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

Thrombosis from lower extremities

DUE TO (c)

466x

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

Chylophorosis lower extremities

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☒ No ☐ Unknown

19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT ☐

SUICIDE ☐

HOMICIDE ☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour a.m. p.m.

Month, Day, Year

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from 8-7-63 to 8-24-63 and last saw her alive on 8-24-63
Death occurred at 6:00 AM m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Name or title)

22b. ADDRESS

22c. DATE SIGNED

23a. BURIAL, CREMATION, REMOVAL (Specify)

Burial

23b. DATE

8/29/63

23c. NAME OF CEMETERY OR CREMATORY

Calvary Cemetery

23d. LOCATION (City, town, or county)

St. Louis

Mo.

24. FUNERAL DIRECTOR

ADDRESS

Cullen & Kelly 7267 Natural Bridge

25. DATE REC'D BY LOCAL REG.

AUG 29 1963

26. REGISTRAR'S SIGNATURE

Harold Smith M.D.

(Licensed Embalmer's Statement on Reverse Side)

USE BLACK INK

OR

TYPEWRITER RIBBON

AMENDMENTS ON THIS RECORD ARE AS FOLLOWS

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

BY AFFIDAVIT OF

DATE AMENDED

2

VS 300 Rev. 4/59

1

2

3

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76

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed

Licensed Embalmer No. 4142

P. O. Address St. Louis

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.